

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
RETIN-A-GEL(tretinoin)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext. and options _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN
LETTER OF MEDICAL NECESSITY**

CRITERIA:

- ▶ Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma
- ▶ Pre-panretin use
- ▶ List number of primary KS lesions
- ▶ Indicate if lesions are flat or raised
- ▶ Estimated total square centimeters

INFORMATION:

- ▶ Not to be used when systemic anti-Kaposi's Sarcoma therapy is required

AUTHORIZATION:

60 day trial on 0.1% Retin-A-gel.

RE-AUTHORIZATION:

Documentation indicating patient has had at least a 25% improvement or more from the baseline. Re-authorization is then for 6 months.

